STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155573	A. BUILDING 00 B. WING	05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	981 BEECHWOOD AVENUE MIDDLETOWN, IN47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 23, 24, 25, & 26, 2011 Facility number: 000342 Provider number: 155573 AIM number: 100289140 Survey team: Angel Tomlinson RN TC Leslie Parrett RN Sharon Lasher RN Barbara Gray RN [May 23, 2011] Census bed type: SNF: 8 SNF/NF: 30 Total: 38 Census payor type: Medicare: 8 Medicaid: 24 Other: 6 Total: 38 Sample: 10 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The facility respectfully submits the following plan of correction as our credible allegation of compliance for the following deficiencies. We request a paper compliance of the deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/3/11 by Jennie Bartelt, RN.			
F0223 SS=A	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to prevent a staff member from forcing 2 residents to take medication when the residents refused for 2 of 2 residents sampled for abuse in total sample of 10 (Resident #10 and Resident #4). Findings include: 1. Review of the record of Resident #10 on 5-23-11 at 10:40 a.m., indicated the resident's diagnoses included, but were not limited to, vascular dementia, psychosis, depression and anxiety. The Minimum Data Set (MDS) assessment, dated 5-23-11, for Resident #10 indicated the following: makes self understood- usually understood and ability to understand others- usually understands.	F0223	Residents #4 and #10 still reside in the facility and have experienced no negative outcomes from this incident.All interview able residents were questioned as part of the initial investigation to ensure no other residents were affected by this practice. The employee was immediately removed from the facility while an investigation into the incident was completed. The employee was terminated following the completion of the investigation.On 6/22/11 all staff will be re-in serviced on facility's abuse policies and procedures; including recognizing abuse and abuse prevention and reporting [Attachment #1].This process will be monitored monthly by all managers through the Guardian Angel rounds using the Quality Assessment "Abuse and Neglect Review" form. [Attachment #2]. Any concerns will be reported immediately to the administrator or DON. The review forms will be	06/25/2011

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	2. Review of the record of Resident #4 on 5-23-11 at 10:52 a.m., indicated the resident's diagnoses included, but were not limited to, senile dementia with depressive features, anxiety and depression. The MDS, dated 4-11-11, for Resident #4 indicated the following: makes self understood- understood and ability to understand others- usually understands. Interview with the Administrator on 5-23-11 at 2:00 p.m., indicated she interviewed LPN #4 about allegations of abuse on 5-6-11. The Administrator indicated LPN #4 admitted to giving medication to Resident #10 and Resident #4 after they refused. The Administrator indicated LPN #4 was able to state the facility policy on residents refusing medication, but did not follow the policy and was terminated. The investigative report provided by the Administrator on 5-23-11 at 2:30 p.m., indicated LPN #4 was observed on 5-4-11 giving Resident #10 medication after the resident refused repeatedly. Resident #10 spit the medication all over his face and upper body. Resident #10 was "visibly upset". LPN #4 then made Resident #4 open her mouth wide and take her medication after she repeatedly said she		reviewed at the monthly Quality Assessment meeting for six months and then quarterly thereafter for six months.	

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	did not want her medicine. LPN #4 was sent home immediately by the Administrator pending the investigation. On 5-6-11 the administrator and Director of Nursing interviewed LPN #4. LPN #4 admitted she gave Resident #10 and Resident #4 medication after they refused. The Administrator terminated LPN #4 based on the LPN did not follow the facility policy for administering medication to residents when they refuse and forcing Resident #10 to "take his medicine when he clearly refused to be abusive." The abuse prohibition, reporting and investigation policy provided by the Administrator on 5-23-11 at 2:30 p.m., indicated the definition of abuse was " physical, sexual, verbal and or mental abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish. 3.1-27(a)(1)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to update and revise a care plan with preventive measures for a tracheostomy tube dislodging for 1 of 10 residents sampled for care plans in a total sample of 10 (Resident #23). Finding includes: Review of the record of Resident #23 on 5-23-11 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, acute respiratory failure, congestive heart failure, anxiety, cerebrovascular accident (CVA) (stroke) and attention to tracheostomy.	F0279	Resident #23 was the only resident found to be affected by this deficient practice.The care plan has been revised to address the tracheotomy collar for resident #23. All licensed nurses will be in serviced on 6/22/11 that only Portex adult tracheotomy collar will be used. This has been placed on the TAR for licensed nurses to monitor that the correct collar is in place and that is secure every shift.TAR documentation will be checked using the "Trach Collar Placement" QA tool. [Attachment#3]. This tool specifically addresses: 1) that Portex adult collar only is in place and is secure, 2) the care plan addresses the appropriate collar, 3) nurses are documenting that	06/25/2011

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	The Minimum Data Set (MDS) assessment for Resident #23, dated, 2-28-11, indicated the following: respiratory treatments- tracheostomy care. The physician's recapitulation for Resident #23, dated May 2011, indicated tracheostomy size 8, oxygen at 10 liters per trachea mask with 100 % humidity and 50 PSI (pressure). The care plan for Resident #23, dated, 2-16-11, indicated the resident had an tracheostomy. The interventions were notify the medical doctor as needed, provide oxygen as ordered, provide trachea care as ordered and suction as needed. The care plan indicated no new interventions added after 2-16-11. The resident transfer form for Resident #23, dated, 4-3-11 at 11:20 p.m. indicated, "Entered resident's room, trach completely out laying next to her in bed," physician notified and an new order was received to send the resident to the emergency room for treatment. The resident's blood pressure was 107/59, pulse was 90, respirations were 24 and temperature was 99.1. The local hospital History and Physical for Resident #23, dated 4-4-11, indicated the resident had a tracheostomy size 8 that		this is being monitored every shift.The "Trach Collar Placement" QA tool will be completed by the DON or designee five times per week for four weeks, weekly for three months and monthly thereafter.	

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	came out at the facility for an unknown amount of time. The resident was tolerating oxygen by a mask and there was no significant respiratory distress or desaturations. Attempts were made by the local hospital to put a size 8 tracheostomy tube back in but this was not able to be done and an size 4 tracheostomy tube was put in. Interview with the Unit Manager on 5-24-11 at 11:25 a.m., indicated the facility did not put any measures in place in attempt to prevent the tracheostomy tube from coming out again. Interview with the Unit Manager on 5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. 3.1-35(a)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the nutritional care plan for 1 of 10 residents reviewed for care plans in a sample of 10. (Resident #34) Findings include: On 5/24/11 at 7:30 a.m., Resident #34 was observed eating breakfast. Resident #34 received 4 ounces of 2% milk. She did not receive a house shake or magic cup with her breakfast. On 5/24/11 at 12:15 p.m., Resident #34's lunch did not include milk, a house shake or magic cup. Resident #34's record was reviewed on 5/23/11 at 10:25 a.m. Resident #34's diagnoses included, but were not limited to, dementia,	F0282	Resident #34: Dietary interventions on the health care plan have been reviewed/revised and the resident is receiving all items as indicated on the plan of care.All residents are at risk for being affected by this deficient practice.Each resident's dietary plan of care will be reviewed by the Certified Dietary Manager or her designee by 6/25/11 to ensure that the items included in the plan of care coordinates with what the resident is receiving on his or her meal tray. The CDM, DON and Unit Manager will update the care plan and menus weekly as interventions are implemented or revised. All nursing and dietary staff will be in serviced on the importance of providing specific food items at meals in accordance with each resident's individual plan of care.The CDM or designee will be responsible to complete the QA tool "Meal Accuracy Audit" [Attachement#4] on two meals a day for a total of ten days. The meals will be varied to include breakfast, lunch, and supper throughout the ten day audit to monitor for and or to identify any systemic issues. Any identified issues will be immediately	06/25/2011

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	Alzheimer's disease, weight loss and a history of dehydration. Resident #34's care plan dated, 3/2/11 with a revision date of 5/16/11, indicated, "Focus, nutritional risk related to: poor food and/or fluid intakes. Goal, resident will remain free from significant weight loss. Interventions, 3/2/11, serve whole milk with meals to increase caloric intake and 4/29/11, serve house supplement shakes at meals and magic cups to increase caloric intake." Resident #34's "weight record" indicated the following: - 2/17/11, 107, pounds - 3/2/11, 107.6 pounds - 4/8/11, 105, pounds - 5/11/11, 101.4, pounds Resident #34's Dietary Registered Dietary (RD) Assessment, dated, 5/24/11, indicated Resident #34 at high risk for nutritional problems. Comments by the RD (Registered Dietitian) indicated, "Alzheimer's		corrected and logged on to the facility's QA tracking log. Following the ten day audit, the QA toll titled Meal Accuracy Audit will be completed by the CDM or designee weekly on all three meals for the four weeks and then monthly thereafter. Results of the audits will be reviewed monthly during the facility's QA meeting to ensure ongoing compliance.	

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	disease, weight loss, (GERD) gastroesophageal reflux , diabetic mellitus, hypertension (high blood pressure), Periactin appetite stimulant. Abnormal labs 5/20/11... Weight 101.4, diet order regular, receives whole milk, house shake, and magic cup with meals. Weight loss 3.5% times 30 days, 5.2% times 90 days, 6.7% times 180 days. Resident #34's most recent "Dietary Manager Assessment and MDS [Minimum Data Set]" dated, 2/28/11, indicated the following: - does resident have orders from physician to receive nutritional supplements with meals or between meals, no - does resident receive dietary provided nutritional supplements (e.g. house shakes, house supplement, no - weight is stable with no loss or gain noted the past year - nutritional care plan initiated or updated, yes - recommendations, none, continue			

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	with current plan of nutritional care Interview with the Dietary Manager on 5/24/11 at 2:35 p.m., indicated the Registered Dietician's last assessment before the one on 5/24/11 was on 1/5/10 and the last assessment she had completed was on 2/28/11. In May 2011, Resident #34 had a weight loss and that was when she added the interventions of the house supplement shakes and magic cups at meals to the care plan. She also indicated Resident #34 had not been receiving the house supplement shakes and magic cups at meal time. 3.1-35(g)(2)			

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F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to provide proper peri care on 1 resident with a history of urinary tract infections (UTI) for 1 of 3 residents reviewed for peri care in a sample of 10. (Resident #34) Findings include: On 5/23/11 at 2:50 p.m., staff CNA #3 was providing incontinence care to Resident #34. Staff CNA #3 washed both sides of Resident #34's groin area and with the same wash cloth she washed Resident #34's peri area, starting at the back and going to the front. During interview on 5/23/11 at 3:00 p.m., staff CNA #3 indicated she was nervous and forgot the proper	F0315	All residents have the potential to be affected by this deficient practice. An inservice will be held on 6/22/11 by the DON for all nursing staff. The inservice will review the policy and procedure for "Peri Care" [Attachment #5]. The policy and procedure includes pedicure and incontinent care. This inservice will be given annually and for all new hires. Skills check offs for perineal care for CNAs wail be evaluated by a nurse manager or RN. This check off is titled "Procedure 34: Perineal Care" [Attachment #6]. These check off will be completed by 6/25/11. Thereafter, the nurse manager or designee will do five skills check offs randomly for four weeks, monthly for four months and then annually.The inservice and skills check offs will done on all new hires.	06/25/2011

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	technique for performing peri care. Resident #34's record was reviewed on 5/23/11 at 10:25 a.m. Resident #34's diagnoses included, but were not limited to, repeated UTIs, urinary incontinence and urinary frequency. Resident #34's physician's order dated, 3/28/11, indicated, "Macrobid (antibiotic) 100 mg (milligrams), by mouth, two times a day, for 10 days related to UTI." Resident #34's physician's order dated, 4/10/11, indicated "Macrobid 100 mg, by mouth, two times a day, for 10 days for UTI." 3.1-41(a)(2)			

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to follow and revise a plan for preventing weight loss or any further weight loss for 1 of 2 residents reviewed for weight loss in a sample of 10. (Resident #34) Findings include: On 5/24/11 at 7:30 a.m., Resident #34 was observed eating breakfast. Resident #34 received 4 ounces of 2% milk. She did not receive a house shake or magic cup with her breakfast.	F0325	Resident #34: Dietary interventions on the health care plan have been reviewed/revised and the resident is receiving all items as indicated on the plan of care.All residents are at risk for being affected by this deficient practice.Each resident's dietary plan of care will be reviewed by the CDM or her designee by 6/25/11 to ensure that the items included in the plan of care coordinates with what the resident is receiving on his or her meal tray. The CDM, DON and Unit Manager will update the care plan and menus weekly as interventions are implemented or revised. All nursing and dietary staff will be in serviced on the importance of providing specific food items at meals in accordance with each resident's	06/25/2011

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	On 5/24/11 at 12:15 p.m., Resident #34's lunch did not include milk, a house shake or magic cup. Resident #34's record was reviewed on 5/23/11 at 10:25 a.m. Resident #34's diagnoses included, but were not limited to, dementia, Alzheimer's disease, weight loss and a history of dehydration. Resident #34's care plan dated 3/2/11 with a revision date of 5/16/11, indicated, "Focus, nutritional risk related to: poor food and/or fluid intakes. Goal, resident will remain free from significant weight loss. Interventions, 3/2/11, serve whole milk with meals to increase caloric intake and 4/29/11, serve house supplement shakes at meals and magic cups to increase caloric intake." Resident #34's "weight record" indicated the following: - 2/17/11, 107, pounds - 3/2/11, 107.6 pounds		individual plan of care.The CDM or designee will be responsible to complete the QA tool "Meal Accuracy Audit" [Attachment #4] on two meals a day for a total of ten days. The meals will be varied to include breakfast, lunch, and supper throughout the ten day audit to monitor for and or to identify any systemic issues. Any identified issues will be immediately corrected and logged on to the facility's QA tracking log. Following the ten day audit, the QA toll titled "Meal Accuracy Audit" [Attachment #4] will be completed by the CDM or designee weekly on all three meals for the four weeks and then monthly thereafter. Results of the audits will be reviewed monthly during the facility's QA meeting to ensure ongoing compliance.	

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	155573	A. BUILDING 00 B. WING	05/26/2011

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MILLER'S MERRY MANOR	981 BEECHWOOD AVENUE MIDDLETOWN, IN47356

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	- 4/8/11, 105, pounds - 5/11/11, 101.4, pounds Resident #34's "Dietary Registered Dietary (RD) Assessment, dated 5/24/11, indicated Resident #34 at high risk for nutritional problems. Comments by the RD indicated, "Alzheimer's Disease, weight loss, (GERD) gastroesophageal reflux , diabetic mellitus, hypertension (high blood pressure), Periactin appetite stimulant. Abnormal labs 5/20/11... Weight 101.4, diet order regular, receives whole milk, house shake, and magic cup with meals. Weight loss 3.5% times 30 days, 5.2% times 90 days, 6.7% times 180 days." Resident #34's most recent "Dietary Manager Assessment and MDS," dated 2/28/11, indicated the following: - does resident have orders from physician to receive nutritional supplements with meals or between meals, no - does resident receive dietary			

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	provided nutritional supplements (e.g. house shakes, house supplement, no - weight is stable with no loss or gain noted the past year - nutritional care plan initiated or updated, yes - recommendations, none, continue with current plan of nutritional care Interview with the Dietary Manager on 5/24/11 at 2:35 p.m., indicated the Registered Dietician's last assessment before the one on 5/24/11 was on 1/5/10 and the last assessment she had completed was on 2/28/11. In May 2011, Resident #34 had a weight loss and that was when she added the interventions of the house supplement shakes and magic cups at meals to the care plan. She also indicated Resident #34 had not been receiving the house supplement shakes and magic cups at meal time. 3.1-46(a)(1)			

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F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to investigate the cause of a tracheostomy tube (an opening in the neck through the trachea to provide an airway) coming out, and failed to put measures in place to prevent it from coming out again for a resident with a tracheostomy that dislodged for 1 of 1 resident sampled for tracheostomy care in a total sample of 10 (Resident #23). Findings include: Review of the record of Resident	F0328	Resident #23 was the only resident found to be affected by this deficient practice.The care plan has been revised to address the tracheotomy collar for resident #23. All licensed nurses will be in serviced on 6/22/11 that only Portex adult tracheotomy collar will be used. This has been placed on the TAR for licensed nurses to monitor that the correct collar is in place and that is secure every shift.TAR documentation will be checked using the "Trach Collar Placement" QA tool. [Attachment #3]. This tool specifically addresses: 1) that Portex adult collar only is in place and is secure, 2) the care plan addresses the appropriate collar, 3) nurses are documenting that this is being monitored every	06/25/2011

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	#23 on 5-23-11 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, acute respiratory failure, congestive heart failure, anxiety, cerebrovascular accident (CVA) (stroke) and attention to tracheostomy. The Minimum Data Set (MDS) assessment for Resident #23, dated 2-28-11, indicated the following: ability to understand others-understands, makes self understood- usually understood, transfer- total dependence of two people, walk in room- did not occur, personal hygiene- total dependence of two people, bed mobility- total dependence of two people and respiratory treatments-tracheostomy care. The physician recapitulation for Resident #23, dated May 2011, indicated tracheostomy size 8, oxygen at 10 liters per trachea mask with 100 % humidity and 50 PSI (pressure).		shift.The "Trach Collar Placement" [Attachment #3] QA tool will be completed by the DON or designee five times per week for four weeks, weekly for three months and monthly thereafter.	

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	The care plan for Resident #23 dated 2-16-11, indicated the resident had a tracheostomy. The interventions were to notify the medical doctor as needed, provide oxygen as ordered, provide trachea care as ordered and suction as needed. The resident transfer form for Resident #23, dated 4-3-11 at 11:20 p.m., indicated, "Entered resident's room, trach completely out laying next to her in bed," physician notified and an new order was received to send the resident to the emergency room for treatment. The resident's blood pressure was 107/59, pulse was 90, respirations were 24 and temperature was 99.1. The local hospital History and Physical for Resident #23, dated 4-4-11, indicated the resident had a tracheostomy tube size 8 that came out at the facility for an unknown amount of time. The resident was tolerating oxygen by a mask and			

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	there was no significant respiratory distress or desaturations. Attempts were made by the local hospital to put a size 8 tracheostomy tube back in but this was not able to be done and a size 4 tracheostomy tube was put in. During observation on 5-23-11 at 3:20 p.m., Resident #23 was lying in bed with a tracheostomy with 10 liters of oxygen, 100% humidity and 50 psi. The tracheostomy had a collar attached around the resident's neck and velcro on each side of tracheostomy to secure it. Interview with the Unit Manager on 5-24-11 at 11:25 a.m., indicated the facility did not do an investigation on how Resident #23's tracheostomy tube came out. The Unit Manager indicated the facility did not put any measures in place in attempt to prevent the tracheostomy tube from coming out again. The Unit Manager indicated she was not sure of the cause of the tracheostomy tube coming out.			

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	Interview with the Unit Manager on 5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had got report and counted medication when an CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident twice and thought the first one was			

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	91%, but could not exactly remember. LPN #1 indicated she did know that the resident's oxygen level never went down. LPN #1 indicated she attempted to reinsert the tracheostomy tube but was unable to get it back in. LPN #1 indicated she placed oxygen 10 liters by a mask over the resident's stoma. LPN #1 indicated she had another nurse stay with the resident and called the physician and the physician gave an order to send the resident to the emergency room. LPN #1 indicated she then called the 911 service for an ambulance. LPN #1 indicated the resident remained stable. LPN #1 indicated the resident talked with her the entire time and indicated to her that she had been asleep and didn't realize the tracheostomy tube had come out. Interview with Resident #23's family member on 5-25-11 at 11:00 a.m., indicated the resident's tracheostomy tube had never come out before. The family member			

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	indicated Resident #23 told her that she didn't know how it happened and she didn't realize it had come out. Interview with the Unit Manager on 5-25-11 at 2:35 p.m., indicated the resident wore an adult size collar with velcro on each side. Interview with Resident #23 on 5-25-11 at 2:40 p.m., indicated she did not remember the incident when her tracheostomy tube came out. Resident #23 was able to whisper and talk, without occluding the tracheostomy. 3.1-47(a)(4)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to document a resident's health status and assessment after the resident's tracheostomy tube dislodged for 1 of 10 residents sampled for documentation in total sample of 10 (Resident #23). Finding includes: Review of the record of Resident #23 on 5-23-11 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, acute respiratory failure, congestive heart failure, anxiety, cerebrovascular accident (CVA) (stroke) and attention to tracheostomy. The Minimum Data Set (MDS) assessment for Resident #23, dated 2-28-11, indicated the following: respiratory treatments- tracheostomy care. The physician recapitulation for Resident	F0514	All residents have the potential to be affected by this deficient practice.All nursing staff will be inservice on 6/22/11 by the DON on "Charting Procedure" [Attachment #7]. Which includes documenting an assessment or progress note for any change in condition. The 24-hour board will be updated as the changes occur.The 24 hour board will be monitored Monday thru Friday by the DON or nurse manager at the daily nurse managers' meeting to ensure all entries on the 24 hours board including progress notes and assessments are carried over to the medical record.This process will be monitored at the daily nurse managers' meeting by using the QA tool "Pertinent Charting Review" [Attachment #8]. Results of these audits will be reviewed at the facility's QA meeting to ensure continued compliance. They will be reviewed monthly for four months, then quarterly for three times.	06/25/2011

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	#23, dated May 2011, indicated tracheostomy size 8, oxygen at 10 liters per trachea mask with 100 % humidity and 50 PSI (pressure). The care plan for Resident #23, dated 2-16-11, indicated the resident had an tracheostomy. The interventions were notify the medical doctor as needed, provide oxygen as ordered, provide trachea care as ordered and suction as needed. The resident transfer form for Resident #23, dated 4-3-11 at 11:20 p.m. indicated, "Entered resident's room, trach completely out lying next to her in bed," physician notified and an new order was received to send the resident to the emergency room for treatment. The resident's blood pressure was 107/59, pulse was 90, respirations were 24 and temperature was 99.1. The documentation did not indicate a full assessment or the resident's status. Interview with the Unit Manager on 5-24-11 at 12:10 p.m., indicated she was unable to find any additional documentation on the incident with Resident #23's tracheostomy tube dislodging. Interview with LPN #1 on 5-25-11 at 9:30 a.m., indicated she was the nurse caring			

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	for Resident #23 when the resident's tracheostomy tube dislodged. LPN #1 indicated she had just come on duty, had gotten report and counted medication when a CNA came and told her Resident #23 needs you. LPN #1 indicated when she went into Resident #23's bedroom her tracheostomy tube was out and lying on her right shoulder, the collar was not secured on the left side and the right side of the collar was still attached. LPN #1 indicated the resident was not in any respiratory distress and was talking with her. LPN #1 indicated she did oxygen saturations on the resident twice and thought the first one was 91%, but could not exactly remember. LPN #1 indicated she did know that the resident's oxygen level never went down. LPN #1 indicated she attempted to reinsert the tracheostomy tube but was unable to get it back in. LPN #1 indicated she placed oxygen 10 liters by a mask over the resident's stoma. LPN #1 indicated she had another nurse stay with the resident and called the physician and the physician gave an order to send the resident to the emergency room. LPN #1 indicated she then called the 911 service for an ambulance. LPN #1 indicated the resident remained stable. LPN #1 indicated the resident talked with her the entire time and indicated to her that she had been asleep and didn't realize the tracheostomy tube had come out.			

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	3.1-50(a)(1)			